pseudo-rheumatic conditions will have to be better separated, and the bacteriology revised.

Pleuritis is another condition which has been traced directly to tonsillar origin. The cases are somewhat isolated as yet, but there is no doubt that this will explain many cases of pleurisy which have hitherto been classed as cryptogenetic.

Another disease of obscure origin which is interesting in this connection is chorea, the dependence of which on rheumatism has long been known. As long ago as 1880 Leube urged the chemico-infectious nature of this disorder, and it is interesting to note that Packard has observed two cases of chorea coming on without intervening rheumatism. Rheumatism has long had the reputation of being one of the diseases which are transmissible to the offspring, the idea being that the hereditary taint consisted in the composition of the blood or the susceptibility of certain parts to rheumatic insult. In the light of our present subject I should rather be inclined to look upon the peculiar conformation of the tonsillar tissue as the thing which is inherited. That this can be and is inherited we well know. Think how enlarged tonsils, adenoid hypertrophy, etc., due to a peculiar lymphatic diathesis, run in families.

Peritonitis, orchitis, hydrocele, mumps, and even an affection of the spinal cord have been traced to attacks of tonsillitis. Forcheimer refers to five cases of jaundice, appearing in each case in less than ten days after an attack of tonsillitis, all gastrointestinal affections having been carefully excluded. He also speaks of two cases of appendicitis which he traces directly to tonsillitis. Cases of nephritis, phlebitis, acute yellow atrophy of the liver have also been described which are supposed to have originated in throat affections. The origin of the so-called rheumatic skin affections and of the febrile exanthemata is also laid in the same locality. How much truth there is in these claims time and observation will tell.

I do not want to leave the subject without speaking of a condition which we see daily, and which is of more importance to us than the occasional acute disturbances for which the lymphoid ring has been blamed. Without bringing up the much-described condition of lymphoid hyperplasia of the oropharynx and its sequelæ, I want to point to the fact that many of these cases are suffering from chronic toxemia. The toxins are prepared either in the deep crypts of the tonsils or in the deep reduplications and folds of the adenoid tissue. Often there will be a chronic abscess in the peritonsillar tissue. From these a constant stream of toxins with all its depressant effects is entering the system, and the removal of these foci alone will produce wonderful results. We have all been highly gratified to notice the improvement, especially in children on whom we have successfully operated for removal of the lymphoid ring hyperplasias. From pale, listless, flabby, flat-chested children, they are transformed in a few months into red-cheeked, bright-eyed, full-chested, ambitious little men and women, whose main difficulty lies in getting enough to eat. Before that they looked like victims of chronic alkaloidal poisoning, and as a matter of fact they were the victims of chronic poisoning, the poison being the toxin elaborated in the tonsil and its allied tissue. We are inclined to think that the improvement is due wholly to the improved oxigenation of the blood through the better facilities afforded for breathing, but I think a large part of the improvement due to the change cited above.

Not only the flora of the mouth, but also the fauna has been accused of pathological mischief. While as yet a theory which will be received with caution, still it is worth mentioning that Paul Cohnheim of Berlin has attributed the origin of carcinomata of the œsophagus and stomach largely to infusoria, trichonomads, which have been found in the mouth, coming from diseased teeth. That dental caries is responsible for the presence of a large number of bacteria is undoubted, and emphasizes the importance of the care of the teeth, and their frequent examination, even by the physician.

I have purposely avoided saying anything about the role played by the tonsils in the production of tuberculosis; not that I underrate their importance in this regard, nor because I could not find numerous references to this point, but because I was afraid that it would carry both myself and those who may be kind enough to discuss this paper, beyond the time limit, were I to take up this phase of the subject.

In closing, I want to acknowledge my indebtedness to Dr. Frederick A. Packard of Philadelphia, whose paper on "Infection Through the Tonsils," read before the New York Academy of Medicine in December, 1899, was the best and most complete article I could find on the subject.

REPORT OF CASES SIMULATING GRAVE MASTOIDITIS.*

By FRED BAKER, M. D., San Diego.

STRANGE or rare conditions involving difficulties of diagnosis in diseases which endanger life or the integrity of important function are always worth reporting. The following case fulfills these conditions, while the succeeding cases, though less interesting and important, illustrate another phase of the same disease:

Case 1—J. C., male, age 19, was referred to me May 22, 1900, by Dr. J. C. Larzelere of Escondido, for polypus in the right ear. I removed the polypus, which was protruding through a medium-sized perforation of the drum, with snare and forceps, and cauterized the stump with pure chromic acid. Healing was rapid, and I discharged him on July 6, 1900, with a sound drum membrane and hearing distance equal to 9-48 by the watch test. At the start, marked dizziness was present, so greatly aggravated by pressure on the polypus that operation was extremely tedious, and somewhat difficult. The patient suffered from severe pain, centering in the mastoid, but there was no swelling, no great aggravation of the pain on pressure or percussion, and the temperature was normal during the whole time that he was in my charge. At first I feared that a mastoid operation would be necessary, and warned the patient's friends of the fact; but as all unfavorable symptoms gradually disappeared, the idea was soon abandoned. February 22, 1901, the same patient drove to town, a distance of about forty-three miles; but as I was absent from home I did not see him until the morning of the 23d. The history given was as follows: About ten days before, he had been taken down with "grip." There were several days of chilling, with high fever, after which he improved. Then he got up and attempted to do some work. Almost immediately he had a severe earache on the side previously affected, resulting in rupture of the drum and a very free discharge. Supposing that now the ear disease was the only important matter, he came directly to me. I found a large opening in the lower anterior portion of the drum, from which issued a free mucopurulent discharge; temperature 101.2; pulse not recorded, but averaging rather slow for the temperature, this proving the rule throughout the sickness; general appearance very bad, which I ascribed to the forty-mile drive of the preceding day. Patient complained of some dizziness and of very severe pain in the ear and mastoid. The mastoid region was swollen, somewhat boggy to the touch, and both pressure and percussion increased the pain. His mother reported that at midnight he had suffered from a severe chill, followed by high fever, which had subsided gradually. Nearly every case of suppurative otitis media accompanying "grip" which has come under my observation has been complicated by more or less mastoid pain. Every such case has made me anxious, but so far, possibly by a large measure of good luck, I have not operated in a single case, nor has any such case proved to be a mastoiditis. A considerable series of such cases without the necessity for operation has made me willing to take some chances, so I did not operate, but began palliative treatment. Just at midnight I was called by telephone; found patient shaking as if in an ague chill, and temperature at 105.5; was able to control the chill and temperature very quickly with whisky, phenacetin and dry heat, and by morning the condition was almost the same as the day before, the temperature having gone down to 101.4. Early in the morning (February 24), I called in consultation Drs. T. L. and C. L. Magee. Dr. C. L. Magee made a blood count, reporting a trifle less than 9,000 white blood corpuscles to the cubic millimeter. We decided that he did not have

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streptococcic infection to account for the chills, and that the count gave rather positive indications against serious mastoid invasion. I explained the situation and chances to the mother, received permission to operate, made preparations for rapid work should it be necessary, and sat down to await developments. For twenty-four hours I practically lived with my patient. At about 1:30 of the morning of the 25th he had another sharp chill, but it was of shorter duration than that of the night before, and the temperature only reached 104. A blood count early in the morning showed the white blood cells at less than 9,000. There was no increase of pain, and the temperature during the day ranged about 101. I had twice given a sharp calomel laxative, and by the evening of the 25th had induced a moderate diarrhea, which showed the typical pea soup discharges of typhoid fever. The bowels were slightly tender, petechiæ were found the next day, and, to our surprise, instead of "grip," we had on our hands a typical case of typhoid fever of moderate severity, which ran a normal course to complete recovery. All the grave aural symptoms subsided rather promptly, and on April 8th I allowed the patient to be taken home on a stretcher, with his ear drum again healed, hearing distance 8-48 by the watch test; no pain or tenderness present, but occasional slight dizziness on sudden motion. He made an uninterrupted recovery, and up to some time last year, when last heard from, had had no recurrence of aural disease.

Case 2—R. S., male, age 7. Patient called at my office on the afternoon of December 26, 1899. He was suffering from a moderate attack of earache on the left side. The drum was only slightly congested, and the pain subsided with free doses of phenacetin and dry heat. About midnight of the 27th the pain returned, and the drum perforated within two hours. I was not called, and did not see the patient till nearly noon of the next day. There was very free serous discharge from a large perforation in the posterior portion of the drum. Temperature normal, and only slight pain. The ear was treated with antiseptic irrigation, and did nicely till January 1, 1900, when the patient had a slight chill, pain in the ear, and mastoid began, and temperature began to rise gradually. The pain was intermittent, and at times very severe. There was constant tenderness on pressure over the mastoid. This condition continued for ten days, during which time the temperature once reached 103. During the whole time the tongue was heavily coated with a marked brown discoloration, and I suggested to the mother that the symptoms were suggestive of a walking typhoid. The mother was indulgent and the boy unmanageable, so that I was unable to keep him in bed until the mother received word of the death of a friend after mastoid operation. Then I was able to keep the boy in bed. He began improving at once; the temperature gradually dropped to normal, pain disappeared, and about January 19th the drum had healed, and I discharged him February 6th, with normal hearing.

During the sickness I felt sure the pain was neuralgic rather than inflammatory, and had little expectation of being obliged to operate. I am unable to account for the continuance of the fever, but believe it was due to some autointoxication. In the light of the history of case 1, and in view of the gradual access of the graver symptoms, my guess of walking typhoid, not very seriously made, may have been a true one.

The patient had a large adenoid to which his ear disease was probably due. This I removed with very marked benefit as soon as he was in condition to stand the operation.

Case 3—M. B., female, age 13. Referred by Dr. C. J. Baker for earache; is of neuralgic habit. For several years has been subject to occasional attacks of sharp pain in the right ear, usually accompanied by slight congestion of the drum. Her mother gives the same history, extending over thirty years, but only once threatening suppuration. January 8, 1897, patient came down with an unusually severe attack of chickenpox, confining her to her bed for five days. She was convalescing, and had been in school a day or two when she had a sharp attack of "grip." She was just recovering from this when a severe pain in the right ear led me to assume charge of the patient. I found the drum extensively congested, but not bulging. Ill-advisedly I did not perforate, and was much surprised that perforation took place in the night with little, if any, increase of pain. When I saw the patient in the morning there was a very free serous discharge from an opening, the location of which I did not note. Pain was continuous but not severe. I did not take the temperature. In the early evening she had a slight chill and steadily increasing mastoid and ear pain. For three days the temperature ranged from 100.5 to 103.5; pain and tenderness over the mastoid were severe. There was, however, little swelling or edema, and pain was increased about as much by superficial as by deep pressure. Two aurists called in consultation favored an operation, but I took the responsibility of a refusal, and the patient made a perfect recovery, with hearing quite markedly above normal.

In April, 1903, the same patient had an attack of "grip," which kept her in bed several days, and out of school nine days. On the morning of April 14th she went to school for the first time after her sickness. About 2 P. M. her right ear suddenly began to pain her. She came to my office about 3:30, with the ear very considerably injected. I sent her home, and at 5 o'clock, having learned discretion from her former otitis, I perforated the drum freely. There was quite free bleeding, but it was well into the night before a serous discharge began. During the next twenty-four hours all the classic symptoms of mastoiditis, except the chill, supervened. For three or four days mastoid pain was severe; there was a moderate continuous fever, the temperature once reaching 103. There can be little doubt that some aurists would have considered operation necessary; but without operation the patient made a rather rapid recovery, again attaining supernormal hearing.

These cases have been reported to show that the last word has not been said about suppurative otitis media by those aural surgeons who maintain that all patients must be operated upon where mastoid pain of severe character persists over thirty-six hours, if accompanied by high temperature, especially if there are also chills of apparent septic character.

I believe this dictum to be true in uncomplicated suppurative otitis media when the discharges are distinctly purulent in character, and in such cases a blood count practically always shows marked increase of the white blood corpuscles; but in serous otitis, or where there is evidence of grippal complications to account for pains of neuralgic type, long chances can be taken with a reasonable certainty of safety.

CONGENITAL DISLOCATION OF THE HIP*

By P. C. H. PAHL, M. D., Los Angeles.

IT IS THE aim of this paper to briefly review the literature on the subject at the writer's command; to report a series of patients operated upon by Dr. Lorenz during his visit to Los Angeles in November, 1902, which came under my observation; and to state the conclusions of the author deduced from the literature read and the patient observed.

Definition.—A condition where the head of the femur is not in the acetabulum when the child is born.

Cause.—The dislocation or misplacement may occur during embryonic life, as shown by Heusner, who observed a five months' fetus with a dislocated hip presenting a lax condition of the joint. The head of the femur could be readily rotated and placed above and below the socket. The ligamentum teres being long and attenuated, the socket shallow, especially posterially where the head had been resting for some time, and the condition about the joint showing plainly that the head of the femur had never occupied the acetabulum.

The dislocation does occur during labor, as shown by a specimen observed by the writer, the right hip being forcibly dislocated, and upon examination does not show a distinct tear in the capsule, nor is the ligamentum teres entirely torn, and from the appearance of the capsule, and the ligamentum teres, one could readily imagine that the condition presented would become identical with those found in congenital hip dislocation in afterlife.

Frequency.—Dr. Leonhardt Rosenfeld, of Nurnburg, reports 917 cases of deformity of the lower extremities in which congenital dislocation of the hip occurred 155 times, or 16.9%. In the 155 cases, 20 occurred in the male, or 12.9%; 133 female, or 87%; 7 times as frequently in the female as in the male. In the female it occurred on the left side 52 times, or 33.5%; on the right side it occurred 54 times, or 34.8%, and double in 49 cases, or 31.7%, showing that the one-sided dislocation occurs more than twice as

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